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ABSTRACT

The traditional counseling model which has evolved out of experiences with upper and middle class clients and presupposes a person who is verbal, self-insightful and motivated toward increased self understanding is not effective in helping the behaviorally disordered. Although these individuals who are usually poor, culturally deprived and have grossly disordered life styles are unsuitable candidates for traditional therapy, they demonstrate a high need for assistance in changing their circumstances. The current procedure of determining the eligibility of persons for rehabilitation entails the substantiation of a medically demonstrable disability that constitutes a handicap to employment often prevents the behaviorally disordered from obtaining needed help. It is suggested that the definition of disability be broadened to include those handicapped in translating their potential into fulfilling economic and social roles because of developmental deficits. A number of innovative programs have been initiated by governmental agencies which suggest more effective ways of working with this population. Non-professional personnel have been used to meet manpower shortages in vocational rehabilitation, and the outreach concept, whereby professional personnel are out-stationed in poverty areas, has been implemented. (RM)

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COUNSELING NEEDS OF THE DISADVANTAGED: CHANGING COUNSELING ORIENTATIONS[1]

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Issues in delivery systems: Behavioral scientists have begun to take a hard look at traditional "counseling" delivery systems as the only or best approach for all persons. The traditional counseling system is composed of: the "fifty minute" hour, the professional counselor, a client, and a professional-type office. "Behind the closed door," the counselor utilizes verbal interchanges between himself and his client to alter client behavior "beyond the closed door." The sources of the disenchantment with this traditional "fifty minute" hour approach are quite diverse. However, the fundamental basis is the lack of evidence for its general effectiveness. That is to say, the traditional counseling model has not worked particularly well with a variety of clients. In addition, it is inefficient, time consuming, and tends to work least well with those who need it most.

To place the issues in perspective, the fifty minute hour approach has evolved, primarily, from the experiences of therapists with upper- and middle-class neurotics and upper- and middle-class college students. Thus, counseling as it is presently practiced is a middle- or upper-class phenomenon. Persons who appear to profit from it are those who: show a willingness to communicate problems and feelings to others, have high needs for achievement, higher social class background, more formal education, higher

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measured intelligence, and greater anxiety and self-dissatisfaction. In general, the best prospect for success with the traditional counseling approach would be characterized as not particularly disturbed, well motivated, well educated, and with good personal resources. A review of the list of "good" clients leads one to the conclusion that such clients would be excellent prospects for success in almost anything. It may be more than remotely possible that it is the nature of the client population rather than the approach that is responsible for successful outcomes utilizing traditional counseling approaches.

To summarize, the traditional counseling model evolved out of experiences with upper- and middle-class neurotics and upper- and middle-class college students. It is based on a doctor-patient relationship and presupposes a client who is verbal, self-insightful and motivated toward increased self understanding, i.e., an upper- or middle-class client.

In the past, the vast multitudes of persons found unable to profit from the traditional approach were typically classified as unsuitable candidates for counseling or psychotherapy. The numbers of persons now classified as such include: the delinquent, the multi-problem family, the poor, those with low intelligence, the non-verbal, the severely disturbed, and those with poor impulse control. These numbers seem to include the majority of individuals needing assistance in improving their circumstances.

Other sources of dissatisfaction with the current approach are to be found in critiques of the medical model, diagnostics, counseling process, and manpower problems. First, in reference

to the medical model, a sizeable number of professionals using the traditional approach make use of the disease or medical model. Simply stated, a set of symptoms are identified, a differential diagnosis made, treatment prescribed, and the cure follows. Such an approach presupposes either a defective organic structure or maladaptive intrapsychic equipment. Both posit intrapsychic pathology to be removed through accurate diagnosis and treatment, resulting in a healthy, well-functioning organism. Szasz (1960, 1969), a psychiatrist, and Albee (1966, 1968), a psychologist, have been outspoken opponents of the medical model. It is their thesis that mental illness, as such, does not exist, and that what is called mental illness is qualitatively different from any other sickness. Albee finds little use for the metaphorical mental apparatus of the psychoanalytic school. Szasz insists that much of what falls under the rubric "mental illness" is no less than sophisticated name-calling.

Diagnostics, the sine qua non of those operating within the parameters of the medical model, has come under increasing attack. There is substantial evidence now available to suggest that most of our diagnostic efforts are a time-consuming nuisance. Our diagnostic instruments have low reliability and low predictive validity for individual clients.

The so-called "counseling process" has also come under attack. Its most severe critics contend that its existence has not as yet been demonstrated. Its more charitable critics contend that sole attention to the fifty-minute hour process dooms this professional area to a short life. As indicated, only a minority

of persons in need of behavioral change are able to profit from the traditional fifty-minute hour approach. The essence of this particular criticism would be found in the contention that we should devote our effort to demonstrating successful outcomes and cease molecular examination of what goes on in that "tricky little" fifty-minute process.

Manpower demands have also been a source of dissatisfaction with the current fifty-minute hour approach. Critics insist that our present manpower model but scratches the surface of those in need of assistance. Thus, it is asserted that the majority of time spent by professional counselors, therapists, psychiatrists, etc., is spent with those who need help least.

Current Practices with the Behavioral Disorder Client

One of the client groups that appear to fit least well with the traditional model is the poor person with a grossly disordered life style who is classified in the so-called "behavioral disorder" category. The incidence of delinquency, "promiscuity", alcoholism, and many other social problems related to behavioral disorders tends to increase as we move into the lower socio-economic stratum (or the "culturally different" now in vogue as a euphemism for "black" or "poor").

The poor, both black and white, tend to be over-represented in the behavioral disorder category. Their learning contexts have not led them to develop an orientation toward the future, to be planful, to be verbal, to be self-knowledgeable, etc. Their experiences have led them to believe that they have little control over their own fate. While the middle-class person tends to

attribute causality of his life to inner forces, one who is poor tends to attribute causality to external and arbitrary forces and pressures.

For these reasons, the poor are generally unsuitable as candidates for traditional counseling and psychotherapy. Their developmental history has been sufficiently different from middle- and upper-class clients such that their goals, aspirations, expectations, etc., vary greatly. The poor tend to make little use of traditional counseling services. They will not wait for services; they will not seek out services.

Despite the low utilization of counseling services, the poor, as a group, show high need for assistance in changing their circumstances. As indicated, they are over-represented in the behavioral disorder category. And, there is greater incidence of markedly disordered lives, alcoholism, promiscuity, "mental illness," etc. (e.g., Hollingshead & Redlich).

Behavioral Disorder as a Disability Category

Rehabilitation has used a rather convenient procedure for determination of the eligibility of persons for rehabilitation services. In order to be deemed eligible for rehabilitation services, it must be substantiated that a person has a medically demonstrable disability; that this disability constitutes a substantial handicap to employment; and that there exists a reasonable expectation that rehabilitation services will aid in the eventual attainment by the person of suitable employment. This formula was developed from early work with the physically disabled. It worked rather well with this population. To illustrate, it is a relatively simple

matter to determine the physical limitations accompnaying a particular amputation and not too difficult for the counselor to relate this to employment limitations. However, in the instance of the mentally retarded and mentally ill, the formula becomes a bit more difficult to apply. When applied to poor people who have so-called behavioral disorders, its usefulness has distinct limitations.

It is in this particular disability category that the traditional eligibility determination triad operates essentially as a "convenient fiction" in the scientific sense of "constructs", "idealizations", "as if" notions. This is not to deny that identifiable behavioral disorders exist or that such disorders constitute a substantial handicap to employment, nor that rehabilitation can be of substantial assistance to such persons. Rather it is to suggest that the concept of medical disability as it applies to the poor classified as behaviorally disordered is a "convenient fiction" in the same sense that "purely economic man" is a "convenient fiction". It is quite unlikely, therefore, that "behavioral disorder" constitutes a genuine nosological or disease category when applied to the poor. The issue of "mental illness" as a genuine medical disability, of course, may be debated. However, poor people have demonstrable deficits related to employment skills; these constitute a handicap to employment; the only merit for classifying such deficits as medical disabilities is as a conceptual shorthand, a linguistic tool from which to develop appropriate rehabilitation strategies.

The ad hoc committee on "Curriculum Development on the Culturally Disadvantaged" (1969) proposed one definition of the culturally disadvantaged: "The culturally disadvantaged are those persons who are handicapped in translating their potential into self-fulfilling

economic and social roles because of developmental deficits which are manifested in such areas as the following:

1. A history of continued failure and negative reinforcement as a result of temporary or dead-end employment and extended unemployment. Lack of vocational skills.

2. Frequent low self-esteem, alienation and easy discouragement.

3. Multiple and complex barriers to employability including inadequate or inferior education (lack of basic skills in reading, math, etc.), chronic health problems, police records, discriminatory hiring practices on the part of employers, lack of transportation to jobs, and, for women, often a lack of adequate child-care facilities.

4. Presence of immedicate financial crisis.

5. Resistance to and the inappropriateness of many paper and pencil type standardized assessment devices.

6. Wide differences in values and frequent confusion in value systems. Work attitudes and motivation may be very different from those of the dominant society.

7. Low frustration tolerance for perserverance in lengthy developmental programs.

8. Most clients from economically disadvantaged backgrounds are members of minority groups. Families are likely to be large. The proportion of households headed by women is substantial.

9. Resistance to change.

10. Reluctance to take risks.

The Committee goes on to note that the definition contains three important dimensions: the essences, causes, and symptoms of cultural deprivation. For the purposes of vocational rehabilitation, the essence of cultural deprivation was seen as "the inability to achieve satisfying social and vocational or occupational identity. The causes of this deprivation are familial, educational, psychological, economic, and social resulting in symptoms of frustration, mistrust, dependency and

alienation." We would advocate a similar view of the behaviorally disordered.

Thus, though behavioral disorders occur with greater frequency among the poor, we do not consider it useful to view such disordered lives in medical terms. West (1969) in reference to poor blacks summarizes the situation quite aptly.

> It seems that the moment "negro and adjustment problems" are mentioned, there seems to be an automatic assumption that man is basically hostile, feels inferior, full of self-hatred and mistrust . . . . with twenty-four years of experience as a negro, I cannot think of any that hates himself although I can think of some that are resentful, distrust whites, and lack self-confidence. Self-hatred in this case is a misnomer. Hatred of the supposedly "democratic system" would be more appropriate. Why should a negro hate himself for not being able to penetrate the system? He hates that which prevents him from penetrating it, the white man and his prejudices. (p. 6-7).

Current Practices

We have indicated that the traditional model of counseling and of service delivery does not work well with persons who have failed to develop middle-class views of what it is to be a client. The mental health delivery system reflects such problems. Typically, the poor person who receives mental health services does not get the "fifty-minute" hour approach; he gets the "pills and needles" approach. There is evidence to suggest that the poor view disability and illness, in general, differently from their middle-class counterparts. It is more socially acceptable for a poor person to remove himself from the labor market due to the "low back syndrome."

Despite accumulated evidence that the behaviorally disordered poor do not profit from traditional techniques, there remains

a tendency for many agencies to continue to look upon persons as unmotivated middle-class clients. Thus, the behaviorally disordered poor are viewed as recalcitrant and uncooperative or as being a product of a hostile, unyielding environment, or as "damaged" or stupid. With such views, such clients are, therefore, seen as hopeless.

While the speech system of the poor is quite appropriate for his natural environment, it is inappropriate for the counseling relationship. It, also, does not fit the demands of the traditional counseling relationship. Typically, the client (or counselor) finds the relationship unrewarding and terminates it.

New Delivery Systems

A number of innovative programs have been initiated by governmental agencies, e.g., H.E.W., Department of Labor and O.E.O. Such programs have been initiated to increase the probability of of success in working with the poor, in general, including those who are behaviorally disordered. These programs have met with varying degrees of success. But there are several commonalities in the innovative approaches from which we may draw inferences as to more effective ways of working with this population.

New Models

Experience with behaviorally disordered poor has necessitated reformulation of the disease paradigm into problems of learning. Experiences has shown that although it may be enjoyable to probe for deep, underlying pathology, this approach rarely leads to successful outcomes. Rather, success occurs when we view specific behavior as either adaptive or maladaptive. We can identify

deficits in adaptive behavior and then attempt to teach the client appropriate behaviors.

One-to-one counseling has been found not to be enough. Warmth, understanding, genuine concern for a client may be necessary but not sufficient conditions for success with the behaviorally disordered client. Of course it is important that the counselor communicate to the behaviorally disordered client that he cares and is concerned. But it has been found necessary to expand this to other techniques necessary to effect rehabilitation (Gellman, 1967). The Youth Opportunity Centers, as well as the HRD experimental and demonstration projects conducted in Chicago, Houston, St. Louis, Los Angeles, and Rochester, New York by the USES demonstrate that new techniques must be used with the poor. Use of professional personnel was not enough. In their programs, personal contact, primarily through the use of trained indigenous workers in the homes, hang-outs, etc., was necessary to build the bridge between the employment service and the chronically unemployed.

Gross (1969), reporting on a survey of Youth Opportunity Centers, suggests that traditional counseling techniques are not sufficient for the disadvantaged and suggests <u>self-help</u> "as represented, for instance, by the Opportunities Industrialization Center." He asks the rhetorical question: "what will counselors have to offer these self-help movements? Advice on setting up counseling and job-training and job-finding facilities, and when it is asked, direct assistance." Gross stresses that although the traditional approach works for some we must make it possible "for someone to come - simply as a man - for help and direction (p. 409)." Gross

believes if seeking such help makes a person feel any less than a man (the major danger he sees in traditional programs) then the person needs to turn to a place of his own.

Walker (1968) suggests that a basic error made by most counselors is that of treating behaviorally disordered poor as if they were middle-class neurotics. He posits a client assessment model for the hard-core unemployed developed to answer the question: "What behaviors must be presented in an interview in order for an individual to be hired?" Walker's assessment model consists of the five following areas: (1) ability to explain skills, (2) ability to answer problem questions, (3) appropriate appearance and mannerisms, (4) enthusiasm for work, (5) fine points of the job interview. Walker insists that this assessment model far surpasses the traditional "psychological model"in effectiveness. It does so insofar as (1) it is based upon operational behaviors which can be understood and agreed upon by independent observers. (2) The client himself knows the standard or goal, knows exactly what changes are expected, and what he must do to meet the standard of performance. (3) Clients understand the vocabulary used in the model. The model makes use of specific non-psychological terms to describe behaviors that help the client to understand the information provided him and that encourage him to become involved in trying to change his own behavior.

Support Personnel in Vocational Rehabilitation

Manpower shortages in the helping professions have resulted in the development of a new group of personnel positions "which are variously referred to as auxiliary, ancillary, technical, non-

professional, para-professional, sub-professional, or support personnel (I.R.S. Training Guide, 1969, p. 7)." Support personnel models are being utilized in a variety of rehabilitation settings. Such models have made better use of professionally trained counselors without diminishing quality of services. In fact, there is some evidence to suggest that support personnel models provide for a more effective delivery of services (Truax, 1967). Rehabilitation programs, ES programs, OEO programs, and secondary education programs are now using support personnel. "Indigenous aids" (referring to "poor folk" from the community) have been used with black and Mexican - American populations; long-term - welfare recipients; those "disemployed" due to multiple social, psychological, and educational problems; and the rural poor.

The Outreach Concept

The poor, including the behaviorally disordered poor tend not to seek out services. Therefore, it has been necessary to move toward the outstationing of professional personnel in poverty areas. This has been supplemented by the use of training indigenous aids (as above).

Summary

In the Statement of Missions and Goals developed by the Council of State Administrators, the mission of vocational rehabilitation with behaviorally disordered is specified. We believe that it summarizes our position:

> "In addition to individuals whose disabilities are the result of medically definiable physical or mental impairments (the traditional source of agency clientele), there are added millions who disabilities consist of behavioral disorders

characterized by deviant social behavior or impaired ability to carry out normal relationships with family and community, which may result from vocational, educational, cultural, social, environmental or other factors. Eligibles for vocational rehabilitation services under such a definition may include the public offender, the alcoholic, the drug addict, the socially and culturally deprived, provided these people are truly "handicapped" in finding and holding suitable employment. In considering the relationship of disability to handicapped, one considers all of the factors - environmental, educational and social - which will impede a person's performance and intensify the vocational handicap.

This broader definition of rehabilitation is intended to free state vocational rehabilitation agencies from the restriction imposed by previous definitions of disability and its relation to handicapped, and to enable them to use their services and skills freely to serve handicapped people who obviously can profit from vocational rehabilitation services but who might have been excluded from such services because they did not appear to be "disabled" under traditional interpretations of the meaning of disability. The adoption of this broader definition was wise and will undoubtedly result in a broader use of the knowledges and skills of vocational rehabilitation agencies. (Council of State Administrators, 1965, p. 7-8)."

FOOTNOTE

[1]Paper read at the 1969 annual meeting of the American Personnel and Guidance Association as a part of a symposium on "Counseling needs of the disadvantaged: Conflict, Confrontation, Challenge and Change" sponsored by Division 6 (ARCA).

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